		AND HUMAN SERVICES	u ~ -t	L 1	1-6-111		D: 12/12/2013 MAPPROVED
		& MEDICAID SERVICES	<u>45-</u>		125/14		0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	IPLE CONST NG 01 - MAIN		(X3) DA	TE SURVEY
		445501	B. WING_			12	2/09/2013
NAME OF	PROVIDER OR SUPPLIER	· 	· ·	STREET AD	DRESS, CITY, STATE, 2		10012010
WEST H	ILLS HEALTH AND RE	-HAR		6801 MIDD	DLEBROOK PIKE		
				KNOXVIL	LE, TN 37919		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF EACH CORRECTIVE AC OSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	Corridors are separ constructed with at rating. In sprinklere required to resist the non-sprinklered buil above the ceiling. (at the underside of permitted by Code. waiting areas, dining may be open to the conditions specified be separated from owalls if the gift shop 19.3.6.1, 19.3.6.2.1, This STANDARD is Based on observation failed to have corrido the passage of smooth to the door was warped and work frame to form a smooth to the passage and work frame to form a smooth to the door was warped and work frame to form a smooth to the do	not met as evidenced by: on and testing, the facility or doors capable of resisting ke. on and testing on December is revealed the dining room e right, would not close within resist the passage of smoke. closed, the top of the door uld not close within the door	K 01	K 017 1. No raffected room had lina Do 2. The assistant closing areas or fected. 3. The raying doors made assistant closing areas or fected. 4. The raying doors made assistant closing areas or fected. 4. The raying doors made assistant closing areas or fected. 4. The raying doors made assistant closing monthly Results Administration doors made assistant close assi	esidents were identified. A new entrance of as been ordered by a fors on 12/20/13. Maintenance Directors assessed all fire of to seal off the passar 12/9/13. No other an aintenance assistar by the Maintenance Directors and only preventative maint of findings will be restrator or Maintenance Performance for 3 months and recent compliance is a Assurance Performance Consists of the A Director, Director of the Coordinator, I is, Dietary, Social Seas Office Manager, Matation Department, ironmental Department, ironmental Department.	fied as having been door to the dining manager of Caro- or and maintenance doors for proper age of smoke in all doors were af- or will audit all fire oper closing and going during enance rounds, reviewed by the acce Director in the ance Improvement administrator, of Nursing, Staff Environmental rvices Director, Medical Records	
İ		ledged by the administrator		1			1/13/14
ABORATORY	DIRECTORIS OR PROVIDE	R/SUPPLIER REPRESEMENTIVE'S SIGN	ATURE	<u> </u>	TITLE		(X6) DATE
	180 M	m		Adm	ninistrator	12,	131/23

iny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days bliowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: EZPQ21

Facility ID: TN4719

If continuation sheet Page 1 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN			(X3) DATE SURVEY COMPLETED				
		· 445501	B. WING			12/	09/2013
	(EACH DEFICIENCY	EHAB TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	6 	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	N BE	(X5) COMPLETION DATE
K 017 K 029 SS=E	during the exit conf NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing system and/or 19.3.5.4 profits the approved autonoption is used, the approved autonoption is used, the approved applied protect 48 inches from the permitted. 19.3.2 This STANDARD is Based on observation doors to the findings included the findings included the company of the storage of the company of the storage of the company of the storage of the company of	erence on December 9, 2013. FETY CODE STANDARD construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from oke resisting partitions and elf-closing and non-rated or rive plates that do not exceed bottom of the door are .1 s not met as evidenced by: ion, the facility failed to have o hazardous areas. e: ember 9, 2013 between 6:00 revealed the following rooms 0 square feet and were being combustibles. These storage	K 029			enance torage sures eted. er- 3/13 50 all ms osures ye s will inten- Per- 3 t com-	
	1. Room 822 2. Room 706 3. Room 708 4. Room 710 5. Room 711 6. Room 712 7. Room 714 8. Room 715			Director of Nursing, Staff Development Co- ordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environ- mental Department.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/12/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN COMPLETED 445501 B. WING 12/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6801 MIDDLEBROOK PIKE WEST HILLS HEALTH AND REHAB KNOXVILLE, TN 37919 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) K 029 Continued From page 2 These findings were verified by the maintenance director and acknowledged by the administrator K 047 during the exit conference on December 9, 2013. 1. No residents were identified as having been K 047 NFPA 101 LIFE SAFETY CODE STANDARD affected. The electrician with MaGaha has SS=D ordered the two illuminating signs for the exit Exit and directional signs are displayed in doors leading back into the building from the accordance with section 7.10 with continuous courtyard on 12/18/13. illumination also served by the emergency lighting system. 19.2.10.1 2. The Maintenance Director reviewed all the signs in the facility on 12/9/13. No other exit signs needing illumination were found. The electrician with MaGaha will place the illu-This STANDARD is not met as evidenced by: minating signs at the doors in the courtyard by Based on observation, the facility failed to have 12/30/13. exit and directional signs installed at required exits. 3. The maintenance assistants were in-serviced by the Maintenance Director 12/23/13 The findings include: regarding the illuminating and directional exit signs must be placed and seen from any loca-Observation on December 9, 2013 at 7:40 a.m. tion of the interior courtyard. revealed the interior courtyard has 5 doors leading back into the build, only 2 are exits doors. 4. The Maintenance Director will audit all il-The other 3 doors are locked from reentry of the luminating signs monthly and ongoing to enfacility. The 2 required exit doors are not provided sure the signs are illuminating during monthly with illuminated and directional exit signs that can preventative maintenance rounds. Results of findings will be reviewed by the Administratbe seen from any location of the interior or or Maintenance Director in the Ouality Ascourtyard. surance Performance Improvement Commit-

K 056

SS=D

This finding was verified by the maintenance

NFPA 101 LIFE SAFETY CODE STANDARD

If there is an automatic sprinkler system, it is

for the Installation of Sprinkler Systems, to

installed in accordance with NFPA 13, Standard

provide complete coverage for all portions of the

director and acknowledged by the administrator during the exit conference on December 9, 2013.

mental Department.

tee for 3 months and/or until one hundred percent compliance is achieved. The Quality As-

surance Performance Improvement Committee consists of the Administrator, Medical Dir-

ector, Director of Nursing, Staff Development

Coordinator, Environmental Services, Dietary,

Social Services Director, Business Office

Manager, MDS Coordinator, Rehabilitation

Department, Medical Records and Environ-

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES		·	NTED: 12/12/2013 FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		_	3 NO. 0938-0391 3) DATE SURVEY COMPLETED
<u></u> .		445501	B. WING _		12/09/2013
	PROVIDER OR SUPPLIER ILLS HEALTH AND RE	ЕНАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 6801 MIDDLEBROOK PIKE KNOXVILLE, TN 37919	12:09:2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(XS) COMPLETION TE DATE
K 056	accordance with NF Inspection, Testing, Water-Based Fire F supervised. There supply for the system are equipp switches, which are building fire alarm s. This STANDARD is Based on observatial areas of the facility The findings include Cobservation on Decrevealed the elevator coverage. The facility This finding was verdirector and acknow during the exit confense NFPA 101 LIFE SAF Required automatic continuously maintaic condition and are instanting to the set of the set	m is properly maintained in FPA 25, Standard for the and Maintenance of rotection Systems. It is fully is a reliable, adequate water m. Required sprinkler ed with water flow and tamper electrically connected to the system. 19.3.5 not met as evidenced by: on, the facility failed to have ty fully sprinklered. ember 9, 2013 at 7:53 a.m. or pits do not have sprinkler by elevators are hydrautic. ified by the maintenance eledged by the administrator arence on December 9, 2013. ETY CODE STANDARD sprinkler systems are ined in reliable operating	K 05	K 056	t will 13 se ant- ings e cent r- e cert- t ary,
		not met as evidenced by: on and record review, the			1/13/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/12/2013 FORM APPROVED OMB NO. 0938-0391

CLIVIE	3 FOR MEDICARE	A MEDICAID SERVICES			0	MB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN			(X3) DATE SURVEY COMPLETED	
		. 445501	B. WING	;		12/	09/2013
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
WEST U	ILLO UEALTU AND DE			6	801 MIDDLEBROOK PIKE		
AAE91 U	ILLS HEALTH AND RE	EHAB			(NOXVILLE, TN 37919		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1		,		
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPULATION OF THE PROPULATION OF THE PR	BE	(X5) COMPLETION DATE
K 062	Continued From pa	ne 4	K (าคว	K 062		
•		ntain the automatic sprinkler		JUZ	t .		
	system.	main the automatic sprinkler			1. No residents were identified as havi	ng	
	System.				been affected. The two sprinkler heads	were	
	The findings include	. .			changed by Morristown Sprinkler, the year obstruction investigation test was	rive	
	The mongs mode	5.			pleted by Morristown Sprinkler, the wa		
	Observation and re-	cord review on December 9,			tor gong is operable and the sprinkler ri	icer mo-	
	2013 between 7:00	a.m. and 11:00 a.m. revealed			room flooding was corrected by Morristown		
	the following: 1. The two (2) connecting breeze ways for the nursing home and nursing home rehab have mixed matched sprinkler heads of quick response				Sprinkler, all completed on 12/13/13.		
					i	ŀ	:
					2. The Maintenance Director and assistants		
					assessed all sprinkler heads to ensure the cor-		
į	and standard response type sprinkler heads.				rect sprinkler heads were in place on 12/13/13.		
	Record review revealed the 5 year				,	,	
	obstruction investigation test is past due.				3. The Maintenance Director was in-ser	viced	
		evealed the water motor gong			on 12/13/13 by the Administrator to ens	sure	
	is inoperable.	·			the five year obstruction tests are comp	leted,	
-	Record review r	evealed the annual main			the water motor gong is operable, all sp	rinkler	
	drain test cannot be conducted due to the				heads match and the sprinkler rising roo	m is	
	sprinkler riser room	flooding.			not flooded.		
	These findings were	verified by the maintenance			4. The Maintenance Director will audit		
	director and acknowledged by the administrator during the exit conference on December 9, 2013.				water motor gong, all sprinkler heads in	the	
V 007					facility, and the sprinkler rising room m	onthly	
		FETY CODE STANDARD		ĺ	and ongoing to ensure the sprinkler head	ds	
SS≍F		and air anaditioning accept.			match, the water motor gong is operable	and	
ļ	with the provisions	and air conditioning comply		ĺ	the sprinkler riser room is not flooded d		
į	with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2				monthly preventative maintenance roun	ds.	
				ĺ	The Maintenance Director will ensure the		
ļ					year obstruction investigation is comple	tea	
į	10.0.2.2	i			when due. Morristown Sprinkler will of the sprinkler riser room, the water motor	JCCK	
İ				ļ	gong, and sprinkler heads quarterly on g	i mina	ŀ
ļ					to ensure all is functioning. All finding	ioning All findings will	
İ]	be reviewed by the administrator or Mai	e reviewed by the administrator or Mainte	
į	This STANDARD is	not met as evidenced by:		1:	ance Director in the Quality Assurance Per-		
		view and interview, the facility			formance Improvement Committee for 3	3	
		e heating, ventilating, and air		ı İ	months and/or until one hundred percen	t com-	
		in accordance with NFPA			pliance is achieved. Quality Assurance	Com-	

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: TN4719 B. WING 12/11/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6801 MIDDLEBROOK PIKE WEST HILLS HEALTH AND REHAB KNOXVILLE, TN 37919 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) mittee consists of the Administrator, Director K 062 of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department. K 067 K 067 1. No residents were identified as having been affected. The four year fire and smoke damper maintenance was started on 12/17/13 by Premier Services and will be completed by 12/31/13. 2. Premier Services will complete the fire and smoke damper maintenance on all dampers by 12/31/13. 3. The Maintenance Director was in-serviced by the Administrator on 12/13/13 the fire and smoke damper maintenance must be performed every 4 yrs. 4. The Maintenance Director will audit all dampers to ensure the fire and smoke dampers are functioning monthly and ongoing during monthly preventative maintenance rounds and Premier Services will perform maintenance on the fire and smoke dampers every four years 1/13/14

vision of Health Care Facilities

BORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

ATE FORM

6899

Administrator

(X6) DATE

If continuation sheet 1 of

PRINTED: 12/12/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN 445501 B. WING 12/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6801 MIDDLEBROOK PIKE **WEST HILLS HEALTH AND REHAB** KNOXVILLE, TN 37919 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL. PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ongoing. Results of findings will be reviewed K 067 | Continued From page 5 K 067 by the Administrator or Maintenance Director 90A. in the Quality Assurance Performance Improvement Committee for 3 months and/or un-The findings include: til one hundred percent compliance is achieved. The Quality Assurance Perform-Record review and interview with the ance Improvement Committee consists of the maintenance director on December 9, 2013 at Administrator, Medical Director, Director of 7:05 a.m. revealed the facility failed to perform Nursing, Staff Development Coordinator, Enthe 4-year fire and smoke damper maintenance. vironmental Services, Dietary, Social Services Director, Business Office Manager, MDS Co-This finding was verified by the maintenance ordinator, Rehabilitation Department, Medical director and acknowledged by the administrator Records and Environmental Department. during the exit conference on December 9, 2013. NFPA 101 LIFE SAFETY CODE STANDARD K 072 K 072 K 072 SS=D 1. No residents were identified as having Means of egress are continuously maintained free been affected. The carts, beds, and general of all obstructions or impediments to full instant items were removed from the corridor by the use in the case of fire or other emergency. No maintenance staff on 12/13/13. furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 2. No other areas were identified for obstruc-7.1.10 tions. All items were removed from the 700 hall leaving the hall clear. 3. All staff will be in-serviced by their department to not store anything in the hallway on This STANDARD is not met as evidenced by: the 700 hall or any other hallway which could Based on observation and interview, the facility cause an obstruction as this is an exit route. failed to have the means of egress continuously All will be in-serviced by 12/31/13. maintained free of all obstructions or impediments. 4. The maintenance director will audit all hallways monthly and ongoing to ensure there are The findings include: no items stored on any hallway during monthly preventative maintenance rounds. Observation and interview with the maintenance

director on December 9, 2013 at 11:05 a.m.

revealed that over the weekend staff would store

on the general tour of the facility the 700 wing exit

items out in the 700 wing corridor. At 6:00 a.m.

corridor was being used for storage. There were

Results of findings will be reviewed by the

Administrator or Maintenance Director in the

Quality Assurance Performance Improvement

Committee for 3 months and/or until one hun-

Quality Assurance Performance Improvement

dred percent compliance is achieved. The

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/12/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN COMPLETED 445501 B. WING 12/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6801 MIDDLEBROOK PIKE WEST HILLS HEALTH AND REHAB KNOXVILLE, TN 37919 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) K 072 | Continued From page 6 K 072 Committee consists of the Administrator, numerous carts, beds, and general items in this Medical Director, Director of Nursing, Staff corridor. The 700 wing is no longer being used for Development Coordinator, Environmental patient use but it is still an exit corridor for the Services, Dietary, Social Services Director, facility. Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records This finding was verified by the maintenance and Environmental Department. director and acknowledged by the administrator during the exit conference on December 9, 2013. NFPA 101 LIFE SAFETY CODE STANDARD K 144 K 144 K 144 SS=F 1. No residents were identified as having been Generators are inspected weekly and exercised affected. under load for 30 minutes per month in accordance with NFPA 99 3.4.4.1. 2. No other areas were identified as being affected by location of annunciator alarm/panels as the other floors are in place. A baby monitor will be placed near the annunciator panel and monitored by the 2nd floor nurse 24hrs/seven days a week. Maintenance will check annunciator panel twice daily Monday through Friday and Weekend Nurse Supervisor will check annunciator panel twice daily This STANDARD is not met as evidenced by: on the weekends until floor is opened. Based on observation, the facility failed to have a 3. Licensed nursing staff and maintenance remote annunciator for the emergency generator staff will be in-serviced by their department in a continuously monitored location. regarding the monitoring of the annunciator panel until the floor is opened. All will be in-The findings include: serviced by 1/2/14. Observation on December 9, 2013 at 8:30 a.m. 4. The Maintenance Director will audit the anrevealed the remote annunciator is located in an nunciator panel twice daily Monday through area of the building that is not in a continuously Friday and Weekend Nurse Supervisor will monitored location. The remote annunciator is audit the annunciator panel twice daily on the

located in the attached assisted living, which is no

longer providing services. The attached assisted

living does not have any offices or staff areas that

are occupied twenty four hours a day.

weekends until floor is opened to ensure there

panel. After the floor opens, then the Mainten-

ance Director will audit the annunciator panel monthly with preventive monthly maintenance

are no alarms sounding on the annunciator

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN	(X3) DATE SUI COMPLET	
		445501	B. WING		12/09/2	2013
NAME OF PROVIDER OR SUPPLIER WEST HILLS HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 6801 MIDDLEBROOK PIKE KNOXVILLE, TN 37919			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COM	(X5) MPLETION , DATE
K 144 K 147 SS=D	director and acknow during the exit confe NFPA 101 LIFE SAI Electrical wiring and	ge 7 rified by the maintenance viedged by the administrator erence on December 9, 2013. FETY CODE STANDARD I equipment is in accordance onal Electrical Code. 9.1.2	K 14	rounds. Results of findings will be rev by the Administrator or Maintenance D in the Quality Assurance Performance provement Committee for 3 months and til one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists Administrator, Medical Director, Direct Nursing, Staff Development Coordinate vironmental Services, Dietary, Social S Director, Business Office Manager, MI ordinator, Rehabilitation Department, N	orector Im- of the tor of or, En- ervices OS Co-	
	Based on observatifailed to maintain electron findings include Observation and tes 6:20 a.m. and 11:00	sting on December 9, 2013 at a.m. revealed the following he corridor were not secured in 508. in 514. in 213.	Ķ 14	Records and Environmental Department 7 K147 1. No residents were identified as have been affected. The Maintenance Direct maintenance assistants secured the followith outlets to the wall: corridor by room 50 ridor by room 514, corridor by room 2 corridor by room 608 by 12/19/13. 2. All corridors were checked by the National tenance Director for loose electrical outleter found.	ng tor and owing 8, cor- 13, and	
	director and acknow	e verified by the maintenance dedged by the administrator erence on December 9, 2013.		3. The Maintenance Director was in-se by the Administrator on 12/13/13 on er the electrical outlets being secured. 4. The Maintenance Director will audit electrical outlets every 3 months x2, the every 6 months ongoing to ensure the eal outlets are secure in the corridors. All ings will be reviewed in the Quality As ance Performance Improvement Comm for 3 months and/or until one hundred prompliance is achieved. The Quality As	t all en lectric- l find- sur- ittee percent	13/14

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ TN4719 B. WING 12/11/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6801 MIDDLEBROOK PIKE WEST HILLS HEALTH AND REHAB KNOXVILLE, TN 37919 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) ance Performance Improvement Committee K147 consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.

Nivision of Health Care Facilities

VIDENSOPPLIER REPRESENTATIVE'S SIGNATURE ABORATORY DIRECTOR'S OF PROT

TATE FORM

EZPQ11

If continuation sheet 1 of 1